

DEPARTMENT OF DISABILITIES, AGING AND INDEPENDENT LIVING

Division of Licensing and Protection 103 South Main Street, Ladd Hall Waterbury, VT 05671-2306 http://www.dail.vermont.gov Voice/TTY (802) 241-2345 To Report Adult Abuse: (800) 564-1612

Fax (802) 241-2358

December 2, 2011

Mr. James Beeler, Administrator Rowan Court Health & Rehab 378 Prospect Street Barre, VT 05641-5421

Provider #: 475037

Dear Mr. Beeler:

Enclosed is a copy of your acceptable plans of correction for the survey and complaint investigation conducted on **September 20**, **2011**. Please post this document in a prominent place in your facility.

We may follow-up to verify that substantial compliance has been achieved and maintained. If we find that your facility has failed to achieve or maintain substantial compliance, remedies may be imposed.

Sincerely,

Pamela M. Cota, RN

Licensing Chief

PC:ne

Enclosure



DEPARTMENT OF HEALTH AND HUMAN SERVICES

RECEIVED Division of

PRINTED: 11/09/2011 FORM APPROVED

| UEPAR II | O COD MEDICADE | MEDICAID SERVICES | | | - | | OMB NO. | 0938-0391 |
|---------------------------------------|----------------------|--|-------------------|---------|--|----------------|------------------------|----------------------------|
| STATEMENT | OF DEFICIENCIES | & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) M | ULTIPLE | CONSTRUCTION | V 2 1 11 | (X3) DATE SU COMPLE | JRVEY TED |
| AND PLAN OF | CORRECTION | IDENTIFICATION NUMBER. | A. BUI | LDING | | ensing and | | o l |
| | | 475037 | B. WII | IG | F1 | rotection | 1 | 0/2011 |
| NAME OF PR | ROVIDER OR SUPPLIER | | | | T ADDRESS, CITY, STAT | E, ZIP CODE | | |
| ROWAN C | COURT HEALTH & R | EHAB | | i | PROSPECT STREET RRE, VT 05641 | | | |
| (X4) ID PREFIX TAG | (FACH DEFICIENC) | NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREF TAC | | PROVIDER'S PL (EACH CORRECTIV CROSS-REFERENCE DEF | /E ACTION SHO | ULD BE | (X5) COMPLETION DATE |
| · · · · · · · · · · · · · · · · · · · | 2011/51/ | TO. | | 000 | | | | |
| F 000 | INITIAL COMMEN | IS | . г | 000 | | | | |
| | An unannounced on | on-site complaint investigation 9/20/11 by the Division of | | | F 281 | | | |
| | t icensing and Prot | ection. The following are | • | | No residents w | vere harmed | by this | |
| E 201 | regulatory violation | s: RVICES PROVIDED MEET | F | 281 | alleged deficit p | oractice | | |
| SS=D | PROFESSIONAL | STANDARDS | | | All Registered N | | | |
| i | The consider provi | ded or arranged by the facility | | | Practical Nurse | s will be inse | rviced on | |
| | must meet profess | sional standards of quality. | : | : | Lippincott's tub | e feeding po | olicy. | |
| | | | | | The LNA lists w | | | |
| : | • | NT is not met as evidenced | | | proper position | ning guidelin | es for tube | |
| | by: Based on record | review and interview the facility ervices that met professional | : | | fed residents. | | | |
| | standards of care | for 1 applicable resident who | i i | | All care plans o | | | |
| | receives gastrosto | omy tube feedings. (Resident | | | tube feedings v | will be reviev | wed for | |
| | #1) Findings inclu | ide: | | | specific positio | ning guidelii | nes. | |
| | 1. Per observation | on 09/20/11 at 2:00 PM, | | | All LNA's will b | e inserviced | on proper | |
| | than upright during | sitting in bed at an angle less g a tube feeding and remained | | | positioning for | | | |
| | at this angle for gr | eater than 1 hour afterwards. | : | | | | | |
| | Per record review | , a physician's order dated current care plan both state | • | | A protractor w | | | |
| | : "the HOB must be | e 45 degrees at all times with | | + | bed of a reside | | | ing |
| | the exception of p | ericare may eat pleasure | | | to ensure bed | is in proper | position. | |
| | food when out of | bed'. Per observation and PM, the unit manager and nurse | | | Audits of all re | scidants that | roquire tu | be |
| | surveyor measure | ed the angle of the bed with a | : | | | | | |
| | protractor and the | e angle was 30 degrees. Per | | 4 | feeding will be | | | <i>J</i> . |
| | interview at 3:30 | PM, the Unit Manager and DNS | | | The audits wil | | | |
| | (Director of Nursi | ng Services) confirmed that the | - : { | | facility QA me | eting x 90 d | ays. | |
| | nead of the bed v | vas not at 45 degrees during and deeding and that the written | | | | | | |
| | care plan as well | as the physician's orders were | | | | | | i . |

SIGNATURE LABORATORY DIRECTOR'S OR PROVIDE

(X6) DATE

Administrator Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days

not followed.

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

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| STATEMENT | OF DEFICIENCIES | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | 1 | E CONSTRUCTION | (X3) DATE SURVEY COMPLETED | |
|------------------------------|--|--|----------------------|--|---|--|
| AND PLAN OF CORRECTION | | | A. BUILDING B. WING | | C 09/20/2011 | |
| | | 475037 | | ET ADDRESS, CITY, STATE, ZIP CODE | 09/20/2011 | |
| NAME OF PROVIDER OR SUPPLIER | | | 378 | PROSPECT STREET | | |
| ROWAN | COURT HEALTH & F | REHAB | BA | RRE, VT 05641 | ECTION (X5) | |
| (X4) ID PREFIX TAG | (EACH DESICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SE CROSS-REFERENCED TO THE AP DEFICIENCY) | HOULD BE COMPLETION | |
| F 281 | Continued From p | | F 281 | The DNS/designee will be for compliance. | responsible | |
| F 282 SS=D | & Wilkins, 8th edit | cott Nursing Manual; Williams ion, page 724. RVICES BY QUALIFIED | F 282 | Corrective Action Complete October 14, 2011 FABI POC accepted 11 | | |
| | must be provided accordance with e care. | by qualified persons in each resident's written plan of | | No residents were harmed alleged deficit practice | | |
| | by: Based on record failed to provide swritten plan of ca regarding care dufeeding. (Resident 1. Per observation Resident #1 was than upright during at this angle for per record review 09/15/11 and the "the HOB must be the exception of food when out of interview at 3:03 surveyor measure protractor and the interview at 3:30 | review and interview, the facility services in accordance with the re for 1 applicable resident uring and/or after a gastrostomy at #1) Findings include: In on 09/20/11 at 2:00 PM, sitting in bed at an angle less ag a tube feeding and remained greater than 1 hour afterwards. It is a physician's order dated current care plan both state e 45 degrees at all times with pericare may eat pleasure bed." Per observation and PM, the unit manager and nurse red the angle of the bed with a e angle was 30 degrees. Per PM, the Unit Manager and DNS | | All Registered Nurses and Lippincott's tube feeding portion of the LNA lists will be update proper positioning guideline fed residents. All care plans of residents retube feedings will be review specific positioning guideline and LNA's will be inserviced positioning for tube fed residents. A protractor will be attached bed of a resident receiving | erviced on olicy. d with es for tube equiring ved for nes. on proper didents. ed to each tube feeding | |
| | (Director of Nurs | sing Services) confirmed that the was not at 45 degrees during and feeding and that the written | l · | to ensure bed is in proper p | JOSICION. | |

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIP | LE CONSTRUCTION | (X3) DATE SURVEY COMPLETED | |
|---|---|---|---------------------|--|-------------------------------|--|
| | | IDENTIFICATION NOMBER. | A. BUILDING | | С | |
| * | | 475037 | B. WING | | 09/20/2011 | |
| NAME OF PE | ROVIDER OR SUPPLIER | | | EET ADDRESS, CITY, STATE, ZIP CO 3 PROSPECT STREET | DE | |
| ROWAN | COURT HEALTH & F | REHAB | , | ARRE, VT 05641 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY) | SHOULD BE COMPLETION | |
| E 202 | Continued From pa | age 2 | F 282 | Audits of all residents ti | hat require tube | |
| F 202 | Continued From po | s the physician's orders were | , | feeding will be done we | ekly x 90 days. | |
| : | not followed. | a the physician a ordera work | | The audits will be reviewed at the | | |
| : | HOLIUNOVVCG. | | | facility QA meeting x 90 | • | |
| • | Refer also to F281 | and F322. | | racincy on meeting x 30 | , auys. | |
| F 322 | 483.25(g)(2) NG T | REATMENT/SERVICES - | F 322 | The DNS/designee will l | be responsible | |
| SS=D | RESTORE EATIN | G SKILLS | | for compliance. | - t | |
| , | Deced on the com | prehensive assessment of a | | ror domphanee. | | |
| | resident the facilit | y must ensure that a resident | | Corrective Action Comp | eletion Date: | |
| İ | who is fed by a na | so-gastric or gastrostomy tube | | October 14, 2011 | _ | |
| | receives the appro | priate treatment and services | | Faba POC accepted | 11/30/11 AMCOTERN | |
| | to prevent aspirati | on pneumonia, diarrhea, | | F 322 | | |
| | vomiting, dehydral | tion, metabolic abnormalities, | | | • | |
| | and nasal-pharyng possible, n ormal e | geal ulcers and to restore, if | | No residents were h | armed by this | |
| | possible, normal c | aurig skillo. | | alleged deficit praction | • | |
| | • | | | · · · · · · · · · · · · · · · · · · · | | |
| | • | ENT is not met as evidenced | | All Registered Nurses | and Licensed | |
| | by: | review and interview 1 | | Practical Nurses will b | pe inserviced on | |
| | Based on record | review and interview, 1 nt who is fed by gastrostomy | | Lippincott's tube feed | ding policy | |
| | tube failed to rece | eive the appropriate treatment | | Elphilottes tabe reet | and bouch. | |
| <u> </u> | and services to pr | event aspiration pneumonia | | The LNA lists will be u | updated with | |
| | and vomiting. (Re | esident #1) Findings include: | | proper positioning gu | • | |
| | : | 00/20/44 at 2:00 PM | | fed residents. | indemined for cade | |
| | 1. Per observatio | on on 09/20/11 at 2:00 PM, sitting in bed at an angle less | | · · · · · · · · · · · · · · · · · · · | | |
| | than unright durin | g a tube feeding and remained | | All care plans of resid | lents requiring | |
| | at this angle for q | reater than 1 hour afterwards. | | tube feedings will be | , , | |
| | Per record review | /, a physician's order dated | | _ | | |
| | 09/15/11 and the | current care plan both state | | specific positioning g | uideiines. | |
| | "the HOB must be | e 45 degrees at all times with | | All LNA's will be inser | viced on proper | |
| | the exception of p | pericare may eat pleasure bed." Per observation and | : | | • • | |
| | interview at 3.03 | PM, the unit manager and nurse | | positioning for tube f | ea residents. | |
| | surveyor measure | ed the angle of the bed with a | | A protractor will be a | ttached to each | |
| | protractor and the | e angle was 30 degrees. Per | | • | | |
| | interview at 3:30 | PM, the Unit Manager and DNS | | bed of a resident rece | | |
| | | | | to ensure bed is in pre- | oper position. | |

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| AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | IDENTIFICATION NUMBER: | A. BUILDING | | | С | |
| | • | 475037 | B. WIN | NG | | 09/20/2011 | |
| NAME OF PR | ROVIDER OR SUPPLIER | | | | T ADDRESS, CITY, STATE, ZIP CODE PROSPECT STREET | | |
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| | | | | | | | |
| F 322 | head of the bed wa | age 3 g Services) confirmed that the as not at 45 degrees during and feeding and that the written as the physician's orders were | | 322 | Audits of all residents to feeding will be done work the audits will be revies facility QA meeting x S | eekly x 90 days. ewed at the 10 days. | |
| | Refer also to F281 | and F282. | | : | The DNS/designee wil | l be responsible | |
| | | | | 1 | for compliance. | | |
| | | | | | Corrective Action Cor October 14, 2011 | 1 | |
| | | | | | F322 POC accepted | 11/30/11 AmostaPN | |
| | | | į · | : | • | | |
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